

FORENSIC & JUVENILE SERVICES INVOICE SUMMARY

Community Mental Health Center: _____

Center #: _____

CMHC Forensic Coordinator: _____

Date of Invoice: _____

Service Provided	Total Number of Claims Submitted	Total Amount Billed	Total Amount Approved for Payment by TDMHDD <small>(For TDMHDD use only)</small>
Forensic (adult)			
Juvenile			
Competency Training/Maintenance			
Other Services (Specify)			
Month Total:			
YTD Total:			

Person Submitting Claims
(Please Print)

Phone Number

Date

TDMHDD Forensic Services Approval

Date